EFFECTIVENESS OF SUPPORTIVE THERAPY IN DECREASING STRESS AND INCREASING QUALITY OF LIFE AMONG SPOUSES OF PEOPLE WITH ALCOHOL DEPENDENCE SYNDROME

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CERTIFICATE

This is to certify that the research work entitled **"EFFECTIVENESS OF SUPPORTIVE THERAPY IN DECREASING STRESS AND INCREASING QUALITY OF LIFE AMONG SPOUSES OF PEOPLE WITH ALCOHOL DEPENDENCE SYNDROME"** was carried out by **Ms. REEMA MATHEW (Reg.No.41091027),** KMCH College of Occupational Therapy, towards partial fulfillment of the requirements of Master of Occupational Therapy (advanced OT in Psychiatry) of the Tamilnadu Dr.M.G.R. Medical University, Chennai.

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CONTENTS

ABSTRACT

AIM:

To determine effectiveness of supportive intervention on stress levels and quality of life among spouses of people with ADS

DESIGN:

Two group pretest –post test quasi experimental design.

STUDY SETTING:

The study was conducted in the Occupational Therapy department of KMCH, Coimbatore.

PARTICIPANTS:

Purposive sampling technique was used and spouses of people with ADS were recruited if they satisfied the selection criteria.

METHOD:

The participants were divided into experimental and control groups. Following the pre-test on PSS-10 AND WHOQOL-Bref, the spouses in the experimental group received supportive intervention. The intervention lasted for two weeks. Post test was done after two weeks for both the groups.

RESULTS:

The participants in the experimental group showed significant reduction in stress levels and significant increase in the physical and psychological domains of quality of life.

CONCLUSION:

The results of this study suggest that supportive intervention can reduce stress levels and improve certain domains of quality of life These results should encourage occupational therapists and other professionals to devise treatment techniques to actively involve the spouse in treatment of Alcohol Dependence Syndrome.

INTRODUCTION

Alcoholism, also known as alcohol dependence, is a disabling addictive disorder. Its characteristics are compulsive and uncontrolled consumption of alcohol despite its negative effects on the drinker's health, relationships, and social standing.

According to the World Health Organisation, there are 140 million alcoholics worldwide. Alcoholism is more prevalent among men, though in recent decades, the proportion of female alcoholics has steadily increased. Current evidence indicates that in both men and women, alcoholism is 50–60 percent genetically determined and 40–50 percent environmentally determined. Most alcoholics develop alcoholism during adolescence or young adulthood (Karrol, 2000).

Although he biological mechanisms underpinning alcoholism are uncertain, risk factors include social environment, stress, mental health, genetic predisposition, age, ethnic group, and sex. Long-term alcohol abuse leads to physiological changes in the brain like tolerance and physical dependence (Agarwal & Kozlowski, 2000).

The serious social problems arising from alcoholism are caused by the pathological changes in the brain and the intoxicating effects of alcohol. Alcohol abuse also leads to committing criminal offences, including child abuse, domestic violence, rape, burglary and assault. Alcoholism also causes loss of employment, which can lead to financial problems. Inappropriate drinking behaviour and resulting reduction in judgment can lead to legal consequences, such as criminal charges for driving or public disorder, or civil penalties for tortuous behaviour, and may lead to a criminal sentence (Gifford, 2009).

A person’s behaviour and mental impairment under intoxication can profoundly impact those surrounding them and lead to isolation from family and friends. This in turn can lead to conflict, divorce, or contribute to domestic violence. Alcoholism can also lead

to neglecting children, with subsequent lasting damage to their emotional development (Gifford, 2009).

Treatment for ADS focuses on helping people discontinue their alcohol intake, followed up with life training and/or social support in order to help them resist a return to alcohol use. Since alcoholism includes multiple factors which encourage a person to continue drinking, preventing a relapse consists of addressing all these. Detoxification followed by a blend of supportive therapy, attendance at self-help groups, and ongoing development of coping mechanisms can help.

Drinking may interrupt normal family tasks, cause conflict and demand adjustive and adaptive responses from family members who do not know how to handle it. Consequently, alcoholism creates a series of escalating crises in family structure and function, which may bring the family to a system crisis, resulting in dysfunctional coping behaviours (Stanley & Vanitha, 2008). Spouses of alcoholics often experience many stressors and heightened emotional distress caused by the negative consequences of the alcoholic's drinking.

Although the substance abuse community recognises that physical and psychological problems are common among families with a substance- abusing member, comprehensive treatment of the families of substance abusers is limited. Failure to provide adequate treatment for these collateral effects of substance abuse on the family is thought to reduce the efficacy of substance use treatment, increase the risk of relapse and leave untreated pathology among family members. Because substance abuse treatment programmes primarily focus on the abuser, they tend to downplay problems that nonabusing family members experience and can even perpetuate the cycle of abuse by leaving family dysfunction and individual pathology of nonabusing members unchecked (Lennox, 1998).

AIMS AND OBJECTIVES

AIM:

- To determine effectiveness of supportive intervention on stress levels and quality of life among spouses of people with ADS

OBJECTIVES:

- To educate participants about nature, course and prognosis of ADS
- To educate participants about effects and management of stress
- To empower participants in being actively involved in maintaining abstinence from alcoholism

OPERATIONAL DEFINITIONS

SUPPORTIVE INTERVENTION

It refers to any treatment given in addition to primary therapy to prevent, control, or relieve complications and to improve a person's comfort and quality of life.

STRESS

It assigns to the consequence of the failure of an organism to respond appropriately to emotional or physical threats, whether actual or imagined. Stress symptoms generally include a state of alarm and adrenaline production, short-term resistance as a coping mechanism, and exhaustion, as well as irritability, muscular tension, inability to concentrate and a variety of physiological reactions such as headache and elevated heart rate.

QUALITY OF LIFE

The Quality of life (QOL) in health care is used to refer to an individual's emotional, social and physical wellbeing, including their ability to function in the ordinary tasks of living.

HYPOTHESIS

- **NULL HYPOTHESIS (H0 1)**

    - Supportive intervention will not have any effect in the levels of stress and quality of life of spouses of people with Alcohol Dependence Syndrome

- **ALTERNATE HYPOTHESIS (H1 1)**

    - Supportive intervention will have an effect in the levels of stress and quality of life of spouses of people with Alcohol Dependence Syndrome

RELATED LITERATURE

CRITERIA FOR SUBSTANCE DEPENDENCE (DSM- 1V)

A maladaptive form of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12 month period.

1. Tolerance
   a) Need for substantially greater amounts of the substance to achieve intoxication or desired effect
   b) Substantially decreased effect with continued use of the same amount of the substance

2. Withdrawal
   a) Characteristic withdrawal symptom of the substance
   b) The same substance taken to retrieve or avoid withdrawal symptoms

3. Substance is often taken in larger quantities or over a longer period than was intended

4. Any successful effort or a persistent desire to cut down or control substance abuse

5. A great deal of time spend in activities necessary to obtain the substance, use or recover from its effects

6. Important social, occupational, recreational activities given up or reduced because of substance abuse

7. Continued use of substance despite knowledge of having had a persistent physical or psychological problem that is likely to be caused or exacerbated by the substance

EPIDEMIOLOGY OF ALCOHOL USE

Alcohol is one of the most extensively used psychoactive substances. Approximately 8 out of 10 persons living in Europe and the Americas report drinking in their lifetime (Edwards, 1994). In India, review of studies till the mid 1980's concluded that alcohol use was predominantly seen in males and the rates for female users of alcohol were less than 5% (Singh, 1989). In a review of studies conducted on inpatient samples, the prevalence of alcoholism ranged from 19%-32% and excessive drinking rated were found to be as high as 50% (Peace, 1987).

FAMILIES OF PEOPLE WITH ALCOHOL DEPENDENCE

Traits like neuroticism, higher anxiety levels, depression, low self-esteem and communication apprehension have been reported in wives of alcoholics and attributed to the intense stress and trauma experienced by her in the already stressful domestic environment that she lives in (Stanley, 2001; Kutty and Sharma, 1988; Rao and Kuruvilla, 1991). Higher levels of marital conflict and aggression have been also documented in couples with an alcoholic spouse when compared to other marital relationships (Stanley, 2006; Stanley & Anitha, 2007). Alcoholism can interrupt normal family tasks, cause conflict and demand adjustive and adaptive responses from family members who do not know how to appropriately respond. Eventually, alcoholism creates a series of escalating crises in family structure and function, which may bring the family to a system crisis and cause the members to develop dysfunctional coping behaviours (Stanley & Vanitha, 2008).

Child in a family with alcohol-abusing parents is at greater risk for mental health problems in comparison to their peers (Whipple & Noble, 1991). Children with alcohol-

abusing parents also are also more likely to experience other risk factors like parental unemployment, lower social class, family conflict (Bennett, Wolin, & Reiss, 1988; Benson & Heller, 1987; Chassin, Rogosch, & Barrera, 1991; Clair & Genest, 1987). Two family characteristics have been found to be particularly important in how children adapt to stress: the emotional climate and the family's characteristic way of dealing with problems. Family cohesion and the emotional bond among family members (Olson, Portner, & Bell, 1982), has been shown to mediate the relationship of stress to family well being (Lavee & Olson, 1991; Olson, Lavee, & McCubbin, 1988) and to correlate with child health or adjustment (Clair & Genest, 1987; Farrell & Barnes, 1993; Miller, Epstein, Bishop, & Keitner, 1985; Walker, McLaughlin, & Greene, 1988). Children of Alcoholics demonstrated higher levels of externalizing behaviour than non Children of Alcoholics and were more likely to exhibit the difficult temperament characteristics (e.g., high activity level) that was hypothesized were precursors to later alcoholic outcome (Jansen et al. 1995).

Exposure to parental substance use disorders predicted substance use disorders in the offspring and adolescence was a critical developmental period for exposure (Biederman, 2000). Offsprings of fathers with alcohol dependence syndrome were found to have beliefs about alcohol that were similar to those of their parents, in contrast to offsprings of non alcoholics. This suggests transmission of paternal beliefs to their children (Shen 2001). Having exposed to a light drinking father increases the risk of a son’s alcohol use exhibited either as hazardous, harmful or dependent drinking. Exposure to heavy or dependent drinking father is associated more uniquely with an increased risk of his son being alcohol dependent (Kornchai, 2002). Adults who were exposed to parental problem drinking in childhood were more likely to develop psychiatric symptoms and marital instability later. To be revealed to a parental problem drinking in childhood is positively associated with specific adverse effects in adulthood even after controlling for other confounding risk factors (Greenfield, 2000).

LITERATURE REVIEW

IMPORTANCE OF FAMILY INTERVENTION

One study integrated a family systems model of alcoholism with a family crisis model for recovery to study spouses of alcoholics and their perceptions of family stress, coping styles, and quality of marriage. Participants (N=60) were spouses of alcoholics who were divided into three equal subgroups: (1) the early recovery group, whose spouses were sober for less than 2 years; (2) the long-term sobriety group, whose spouses were sober 2 or more years; and (3) the wet group, whose spouses were actively drinking. Participants filled out questionnaires about stress, life change events, coping styles, marital adjustment and drinking problems. The results showed that the early recovery group scored lowest in terms of life change events and levels of stress, and highest on the quality of marriage index. The wet group were found to have the highest life change events and stress scores and the lowest scores for the quality of marriage index. The long-term sobriety group scored between on life change events, stress, and quality of marriage. The highest coping abilities scores were in the wet group. Degrees of stress and marital adjustment were inversely related for all groups (O'Connor, 1985).

One study assessed Alcoholics Anonymous (Al-Anon) participation as a factor in stress of wives of alcoholics. Two groups of 20 subjects each were enlisted from Al-Anon, personal contacts, treatment centres, and referrals in three urban areas in the south-eastern United States. Group A wives were not members of Al-Anon, and Group B wives had been members for the past year or longer. Data were obtained from the Stress Audit and a questionnaire specifically designed for the study. Analysis of variance determined that Al-Anon wives were significantly less vulnerable to stress and were significantly less stressed in family situations than were non Al-Anon wives. Significant differences were also found within and between groups as a function of age, education, and status as adult children of alcoholics. Findings suggest that Al-Anon participation significantly reduces

vulnerability to stress, stress from family situations, and the use of maladaptive coping behaviour (McGregor, 1990).

In a paper focusing on an overview of the variety of approaches that have been used in the treatment of alcohol problems, there was good evidence that approaches directed at improving social and marital relationships, self-control and stress management are effective. There was little evidence to suggest that aversion therapies, confrontational interventions, educational lectures or films, group psychodynamic therapy or use of psychotropic medications are effective (Hodgson,1990).

In a review of 38 controlled studies of marital and family therapy (MFT) in alcoholism treatment, it was concluded that, when the alcoholic is unwilling to seek help, MFT is effective in helping the family cope better and motivating alcoholics to enter treatment. Once the alcoholic enters treatment, MFT, particularly behavioural couples' therapy (BCT), is clearly more effective than individual treatment at increasing abstinence and improving relationship functioning. BCT also reduces social costs, domestic violence, and emotional problems of the couple's children (O'Farrell & Stewart, 2003).

Evaluation of the effectiveness of family treatments derived from a family disease perspective based on Al-Anon and 12-step principles, a family systems perspective based on general systems theory, and a behavioural perspective based on reinforcement principles was done in 1989. It concluded "that inspite of the widespread popularity of family-involved alcoholism treatment, there is a paucity of well-controlled research in this area, that all of the research has evaluated marital rather than family therapy, and that there are notable discrepancies between the popularity of clinical practices and the empirical bases of practice" (McCrady, 1989, p.165).

In 1995, Edward and Steinglass reviewed studies from 1972 to 1993 in which they examined effectiveness, cost-effectiveness, and factors influencing effectiveness of family-involved alcoholism treatment. The authors proposed that family therapy is effective in motivating alcoholics to enter treatment, marginally more effective than

individual alcoholism treatment once the drinker has sought help, and modestly beneficial in supporting aftercare and relapse prevention.

Programs that help family members reduce the stressors that children face could lessen the likelihood of child mental health problems in families of people with substance use (Chassin, 1993). Identifying and treating family drinking problems, which likely would involve coordination with community agencies that have direct contact with adults in the community, probably could reduce stress and negative effects on family cohesion. Interventions that strengthen family cohesion, the emotional bonds that family members have to one another could be effective in preventing or treating child mental health problems (Roosa, 1990).

The importance of a family oriented approach integrated with an individual approach has been emphasises in an article on phases of treatment for alcoholics (Neto, 2001). A model for incorporating multifamily therapy was stated as a powerful method to engage families in treatment and promote treatment retention (Conner, 1998). A study conducted in Japan emphasised the role of family treatment programme in increasing patient participation in treatment (Nishikowa, 2001).

A study evaluating three different intervention programmes for spouses of alcoholics: coping skills training, group support and information showed less improvement in the information group as compared to the other two groups. Improvements of coping behaviour, psychiatric symptoms and hardship noted at the 12 month follow up evaluation were still evident in all groups at the 24 month follow up evaluation (Hansson, 2003).

The role of Occupational Therapy in the treating the family affected by alcoholism was also explored. A family treatment approach based on systems theory was organised into three hierarchical treatment levels. Treatment level I focused on reduction of maladaptive role behaviours of the family and treatment level II focused on teaching family members coping skills (Moyers, 1992).

OVERVIEW OF FAMILY INTERVENTION IN ALCOHOLISM

Treatment approaches aim to
(a) Improve family members' coping and well-being
(b) bring in a change when the alcoholic individual is unwilling to seek help
(c) Aid recovery when the alcoholic has sought help

a) Approaches to improve family members' coping and well-being

Other family members including the spouses, often experience many stressors and heightened emotional distress caused by the negative consequences of the alcoholic's drinking. Two approaches try to help family members cope with their emotional distress and concentrate on their own motivations for change rather than trying to motivate the drinker to change.

1) To teach specific coping skills to deal with alcohol related situations involving the drinker
2) To help the family member use the concepts and resources of Al-Anon

Coping Skills Therapy

Zetterlind, Hansson, Aberg-Orbeck, and Berglund (1998) randomly assigned 39 spouses of alcoholics who were not in treatment to coping skills therapy, group support, or a one-session information only control group. Results at 1-year follow-up showed spouses who received coping skills therapy and group support had greater decreases in emotional distress than did the information only control group.

Rychtarik and McGillicuddy (1998) randomly assigned 172 women with male alcoholic partners who were not in treatment to manual-guided coping skills training, a manual-guided Al-Anon facilitation program, or a waiting-list control group. On a role-play observational measure of coping skills, skill training therapy was better than Al-Anon facilitation, and both treatment groups were better than the waitlist control. Spouses in both treatment groups stated less depression and anxiety than those in the waitlist control. Finally, spouses who obtained coping skills therapy received less violence from

their male partners in the year after treatment than did women who received Al-Anon facilitation therapy.

Al-Anon and the 12-Step Family Disease Approach

This 12-step program is the most widely used source of support for family members troubled by a loved one's alcohol problem. Al-Anon advocates that family members detach themselves from the alcoholic's drinking in a loving way, accept that they are powerless to control the alcoholic, and seek support from other Al-Anon members (Al-Anon Family Groups, 1981).

Referral to Al-Anon was examined as a control condition in two studies of methods to initiate change in the alcoholic (Barber & Gilbertson, 1996; Sisson & Azrin, 1986). Referral to Al-Anon did not produce treatment entry or changed drinking habits in either study. This is not surprising because changing the alcoholic is not an Al-Anon goal. However, in the study that measured spouse well-being, spouses referred to Al-Anon reported reduced personal problems related to the drinkers' alcohol use compared to the waitlist control.

AFT is a manual-guided, therapist-delivered counselling method designed to encourage involvement in this 12-step program for families of alcoholics (Nowinski, 1999). Two well-controlled, randomized studies with adequate sample sizes found positive results for AFT. In one study, AFT reduced emotional distress and increased coping behaviours more than a waitlist control for spouses of treatment resistant alcoholics (Rychtarik and McGillicuddy, 1998). In the second, AFT showed significant reductions in emotional distress and family conflict, and improvements in family cohesion and relationship happiness for spouses and parents of treatment resistant alcoholics (Miller, Meyers, & Tonigan, 1999). These AFT improvements were similar to the improvements observed among spouses and parents who received the other interventions studied.

Group therapy based on Al-Anon concepts

Dittrich and Trapold (1984) randomly assigned 23 wives of treatment resistant alcoholics to an 8-week group therapy program based on Al-Anon concepts or to a waitlist control condition. Results showed greater reduction in enabling behaviours, anxiety and depression, and greater increases in self-concept at the end of treatment for the experimental group than for the waitlist control. Similar results occurred for those on the waiting list once they had completed treatment. Progress after treatment were maintained at 2- and 4-month follow-up.

b) Approaches for Initiating Change in the Alcoholic

Four methods were studied with a primary goal of initiating change in the treatment resistant alcoholic in addition to helping the spouse or family member cope better

1) Community Reinforcement and Family Training (CRAFT)
2) The Johnson Institute Intervention
3) Unilateral Family Therapy
4) Pressure to Change

The Community Reinforcement and Family Training Approach

Community Reinforcement and Family Training (CRAFT) is a program for teaching the non-alcoholic family member how to:

(a) Decrease the risk of physical abuse and other dangerous situations

(b) Encourage sobriety by reinforcing nondrinking, extinguishing drinking, and planning competing nondrinking activities

(c) Increase positive relationship communication

(d) Engage in outside activities to reduce dependence on the relationship with the alcoholic

(e) Encourage the alcoholic to seek professional treatment (Meyers, Smith, & Miller, 1998).

In an initial CRAFT study, Sisson and Azrin (1986) randomly assigned 12 family members (mostly wives) of treatment resistant alcoholics to either the CRAFT program or to a traditional disease model program consisting of alcohol education, individual supportive counselling, and referral to AI-Anon. Six of seven people who consumed alcohol entered treatment after relatives had received CRAFT. After their relative started CRAFT, the alcoholics showed more than a 50% reduction in average consumption prior to treatment entry and nearly total abstinence in the 3 months after entering treatment. None of the five alcoholics whose relatives received the traditional program entered treatment and their drinking was not reduced.

In the second CRAFT study, Miller et al. (1999) used a larger sample, equally intensive treatments, and therapists strongly committed to their respective approaches. They randomly assigned 130 concerned significant others (CSOs, i.e., mainly spouses and parents) of treatment resistant alcoholics to

(a) CRAFT

(b) A Johnson Institute Intervention program to prepare for a confrontational family meeting

(c) An Al-Anon facilitation therapy designed to encourage involvement in the 12-step program

All treatments were manual guided with 12 hours of contact planned. The CRAFT approach (64% engagement rate) was significantly more effective in engaging initially unmotivated alcohol abusing adults in alcohol treatment as compared with the more commonly used alternative methods of the Johnson Institute Intervention (22%) or Al-Anon (14%). All three approaches were conjoined with similar significant improvements in CSO functioning and relationship quality. Finally, treatment engagement rates across the three methods were higher for CSOs who were parents than for spouses.

The Johnson Institute Intervention

This method involves 3 to 4 educational and rehearsal sessions to prepare family members for a family confrontation meeting with the alcoholic known as an

"intervention." Confrontation is done to overcome the denial of the alcoholic and promote treatment entry. During the intervention session itself, family members confront the alcohol abuser about his or her drinking and strongly encourage entry to an alcohol treatment program (Johnson, 1986; Liepman, 1993).

Although this method is widely used in treatment centres in the United States, the only randomized study of the Johnson Institute Intervention found that only 22% of CSOs treated with this method were successful in getting their alcoholic family member to enter treatment (Miller et al., 1999).

An earlier uncontrolled study reported similar results in that only 25% of families given the intervention training succeeded in getting the alcoholic to enter treatment. The reason for these disappointing findings is that a substantial majority of families do not go through with the family confrontation meeting. When family members completed the confrontation in these two studies, most succeeded in getting their alcoholic into treatment (Liepman, Nirenberg, & Begin, 1989).

These results are similar to an earlier clinical report that 90% of 60 families who completed the family confrontation intervention meeting got their alcoholic to enter treatment (Logan, 1983).

The Unilateral Family Therapy Approach

Unilateral Family Therapy (UFT) assists the non-alcoholic spouse to strengthen his or her coping capabilities, to enhance family functioning, and to facilitate greater sobriety on the part of the alcohol abuser (Thomas & Ager, 1993). UFT provides a series of graded steps the spouse can use prior to confrontation. These steps are similar to the Johnson approach and adapted for use with an individual spouse.

In an initial pilot study of 25 spouses, spouses who received UFT, as compared with those who did not, had lower emotional distress, higher marital satisfaction, and

greater likelihood that the alcoholic partner had entered alcohol treatment and/or substantially reduced their drinking (Thomas, Santa, Bronson, & Oyserman, 1987).

A second study randomly assigned spouses to UFT or waiting list. The UFT group, as compared with the waitlist control group, had more alcoholic partners who entered alcohol treatment; lower scores on spouse enabling, psychopathology and life distress and higher marital satisfaction (Thomas, Yoshioka, Ager, & Adams, 1990).

The Pressure to Change Approach

The Pressure to Change approach is also for partners living with heavy drinkers who deny their alcohol problem and refuse treatment. PTC involves 5 to 6 counselling sessions to train the partner how to use five gradually increasing levels of pressure on the drinker to seek help or to moderate his or her drinking.

The first PTC study randomly assigned 23 partners living with heavy drinkers who denied their alcohol problem and refused treatment to PTC delivered individually, PTC in a group format, or a waiting list control group. Results showed that almost two-thirds of the drinkers whose partners received PTC made a significant move toward change, compared with none of the drinkers in the waitlist control group (Barber & Crisp, 1995).

Movement toward change was defined as the drinker either

(a) Seeking treatment

(b) Ceasing drinking

(c) Reducing drinking to a level acceptable to the partner and maintaining this change for at least 2 weeks

Two other studies also exhibited greater movement toward change in the drinker for individual, group, and self-help manual versions of PTC than for a wait list control group (Barber & Gilbertson, 1996, 1998).

In 2 of the 3 PTC studies, spouses who received PTC had greater reductions in depressive symptoms and personal problems related to the drinker's alcohol use as compared with the waitlist control.

c) Approaches to aid recovery when the alcoholic has sought help

These approaches refer to treatment in which spouses or other family members of an alcoholic adult were involved in treatment efforts to aid the alcoholic's recovery and help the family after the alcoholic had sought treatment.

Behavioural Couples Therapy

Behavioural couples therapy (BCT) sees the alcoholic patient together with the spouse or cohabiting partner to build support for abstinence and to improve relationship functioning. BCT assumes that spouses can reward abstinence, and that alcoholic patients from happier, more cohesive relationships with better communication have a lower risk of relapse. BCT has two main components: alcohol-focused interventions to directly build support for abstinence; and relationship-focused interventions to increase positive feelings, shared activities, and constructive communication (O'Farrell, 2003).
BCT alcohol- focused interventions have included behavioural contracting (e.g., to promote disulfiram ingestion, daily statements of intent to stay abstinent, or aftercare attendance) and teaching spouses to decrease behaviours that trigger or enable drinking.

BCT with a Behavioural Contract to Maintain Disulfiram as the Alcohol-Focused Method

Azrin (1976) tried to improve the **Community Reinforcement Approach (CRA)** by adding a disulfiram contract in which the spouse or family member observed the patient take disulfiram each day. Male alcoholic patients were randomly assigned to get the standard state hospital alcoholism program (with little or no family involvement) or the standard program plus CRA with disulfiram contract. CRA patients at 6-month

follow-up, compared to standard treated patients, drank less, worked more, spent more time with their families and out of institutions, and were less likely to get separated or divorced. Follow-up for 2 years of CRA subjects showed that positive outcomes for CRA subjects were maintained with at least 90% days abstinent for each 6-month period during the 2-year follow-up.

Azrin, Sisson, Meyers, and Godley's (1982) subsequent CRA study more explicitly evaluated the benefits of disulfiram contracts. Outpatients in a rural community alcoholism clinic were randomly assigned to:

(a) A prescription and instructions to take disulfiram, plus traditional individual counselling based on a disease model approach

(b) A disulfiram contract with spouse or family member, plus traditional individual disease model counselling

(c) Disulfiram contract plus CRA

During the 6-month follow-up period, the two groups that got the disulfiram contract had better disulfiram compliance and better drinking outcomes (i.e., fewer drinking days, less alcohol consumed, and less intoxication) than the traditional group without the disulfiram contract. At 6-month follow-up, the CRA plus disulfiram contract group was almost fully abstinent, drinking on the average 0.4 days a month. The traditional group without disulfiram contract, in contrast, had stopped disulfiram and was drinking on the average 16.4 days a month.

The **Counselling for Alcoholics' Marriages (CALM) Project** BCT program includes disulfiram contracts along with relationship-- focused interventions to increase positive feelings, shared activities, and constructive communication. In the Project CALM disulfiram contract, each day at a specified time the alcoholic asks the spouse to witness the taking of disulfiram and thanks the spouse for doing so. The spouse, in turn, thanks the alcoholic for taking disulfiram and records the observation on a calendar provided by the therapist. Both partners agree not to discuss past drinking or fears about future drinking at home, but reserve these discussions for the therapy sessions. Thus, the CALM contract seeks to restructure the couple's relationship to reduce conflicts about drinking and to decrease the spouse's anxiety, distrust, and need to control the alcoholic.

The CALM contract tries to deal with these relationship dynamics of the early sobriety period in order to increase support for abstinence and reduce risk of relapse (O'Farrell & Bayog, 1986).

An initial Project CALM study randomly assigned 36 couples, in which the husband had recently begun individual alcohol counselling that included a disulfiram prescription, to

(a) 10 weekly sessions of a BCT couples group with a disulfiram contract
(b) 10 weeks of interactional couples group without a disulfiram contract
(c) A no-marital-treatment control group without a disulfiram contract.

During treatment, BCT was better than interactional or individual counselling at stabilizing abstinence and improving marital relationships. During the 2-year follow-up period, the three treatments did not differ on days abstinent and BCT had better marital adjustment and fewer drinking-related problems than individual. BCT and interactional did not differ on days abstinent during follow-up, but wives' marital adjustment remained improved throughout the 2-year period for BCT without improvement for interactional group (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992; O'Farrell, Cutter, & Floyd, 1985).

A second Project CALM study evaluated couples relapse prevention (RP) sessions for maintaining change after BCT. In this study, 59 male alcoholic patients, after participating in weekly BCT sessions for 5 to 6 months, were randomly assigned to receive or not to receive 15 additional conjoint couples RP sessions over the next 12 months. This study produced three major findings.

First, alcoholics who got RP after BCT had more days abstinent, used the disulfiram contract more, and maintained improved marriages longer than those who got BCT alone.

Second, for alcoholics with more severe drinking and marital problems, RP produced better drinking and marital outcomes throughout the 30-month follow-up period.

Third, greater use of the disulfiram contract and more use of BCT-targeted marital behaviours (e.g., shared recreational activities, constructive communication) were associated with more days abstinent and more positive marital adjustment after BCT for all subjects irrespective of the amount of aftercare received (O'Farrell, Choquette, Cutter, Brown, & McCourt, 1993; O'Farrell, Choquette, & Cutter, 1998).

BCT with a Behavioural Contract Other Than a Disulfiram Contract

Hunt and Azrin (1973) did BCT consisting of the couple making written agreements for specific activities each spouse would do to make the relationship rewarding. BCT always included an agreement that the spouse would "discontinue physical and social contact with the client as much as possible" if the alcoholic drank. Sixteen male alcoholic patients were randomly assigned to get the standard state hospital alcoholism program consisting of 25 hours of alcohol education lectures and films (with little or no family involvement) or the standard program plus CRA. CRA patients at 6-month follow-up, compared to standard treated patients, drank less, worked more, spent more time with their families and out of institutions, and were less likely to get separated or divorced.

Hedberg and Campbell (1974) compared behavioural family counselling (BFC) to three individually-oriented behavioural treatments (systematic desensitization, covert sensitization, and electric shock avoidance conditioning) for 49 alcoholic patients at a mental health centre. At 6-month follow-up, BFC was the most effective treatment for all patients regardless of whether the patients' goal was abstinence or controlled drinking; and BFC was particularly effective for patients with abstinence goals.

Male who consumed alcohol who had just completed a 4-week inpatient alcohol program were randomly assigned to

(a) A behavioural contract with a family member (spouse, parent, or sibling) to reinforce aftercare attendance or

(b) Standard aftercare arrangements.

Nearly twice as many contract patients as standard control patients attended aftercare sessions, and patients in the contract condition had significantly more months abstinent and were more likely to be employed and classified as a treatment success (Ahles, Schlundt, Prue, & Rychtarik, 1983; Ossip-Klein, Vanlandingham, Prue, & Rychtarik, 1984).

The Project CALM "sobriety contract"

The Project CALM BCT program also can be used without disulfiram. The disulfiram contract is replaced with a "sobriety contract" in which each day at a specified time the alcoholic patient initiates a brief discussion and reiterates his or her intention to stay abstinent that day (in the tradition of one day at a time). The couple agrees not to discuss drinking or drug use at other times, to mark that they had the discussion on a calendar provided, and to end it with a statement of appreciation to each other (O'Farrell & Fals-Stewart, 2000).

Kelley and Fals-Stewart (2002) randomly assigned 71 married/cohabiting men with a primary alcohol dependence diagnosis for a 20-week period to one of three equally intensive 32-session outpatient treatments:

(a) BCT consisting of 12 BCT sessions and 20 individual cognitive behavioural therapy sessions

(b) Individual-Based Treatment (IBT) consisting of 32 individual cognitive behavioural therapy sessions

(c) couples-based Psycho educational Attention Control Treatment (PACT) consisting of 12 couple education sessions and 20 individual cognitive behavioural sessions. Results in the year after treatment showed that BCT produced more days abstinent and more positive scores on relationship adjustment measures than did IBT or PACT.

Fals-Stewart, O'Farrell, and Birchler (2001) randomly assigned 80 married or cohabiting male alcoholic patients for a 12-week period to either

(a) Brief BCT (12 sessions BCT sessions alternating with 6 individual sessions)

(b) BCT (24 sessions-12 BCT sessions alternating with 12 individual counselling sessions)

(c) IBT (12 individual sessions)

(d) PACT (12 individual sessions alternating with 6 educational sessions for the couple)

Both BCT versions used the sobriety contract. Group comparisons indicated Brief BCT and BCT were significantly more effective than IBT or PACT, with BCT having more days abstinent and more positive relationship adjustment scores during the year after treatment.

Fals-Stewart and O'Farrell (2002) added naltrexone observation by the spouse to the sobriety contract in a recent pilot study. Naltrexone is a recovery medication that reduces cravings and desire to drink and improves drinking outcomes.

In this study, 80 male alcohol-dependent married or cohabiting men were randomly assigned to one of four equally intensive 12-week treatment conditions. In all conditions, individual counselling sessions consisted of 12-step facilitation, the treatment as usual (TAU) provided by the treatment program. All patients were given a prescription for naltrexone, which they were encouraged to take by the agency physician as part of their treatment regimen. Treatment conditions were:

(a) BCT with daily naltrexone contract to observe and reinforce naltrexone ingestion plus individual TAU sessions (BCT-NC)

(b) BCT without daily naltrexone contract plus individual TAU sessions (BCT)

(c) PACT of couple education about alcoholism plus individual TAU sessions (PACT)

(d) TAU individual sessions only (TAU).

Results during the 12-week treatment phase and a 6-month follow-up period showed that the BCT-NC group with the sobriety plus naltrexone contract produced better naltrexone compliance and a trend toward more days abstinent than the other three treatment conditions.

BCT with an Alcohol-Focused Method Other Than a Behavioural Contract

Some BCT studies have used an alcohol-focused method other than behavioural contracting. Noel and McCrady (1993) developed a method called "**alcohol-focused spouse involvement**."

It involves teaching the spouse specific skills to deal with alcohol-related situations. The spouse is taught how to reinforce abstinence, decrease behaviours that trigger drinking, decrease behaviours that protect the alcoholic from naturally occurring adverse consequences of drinking, assertively discuss concerns about drinking-related situations, and respond to help the drinker in drink refusal situations.

McCrady et al. (1986) randomly assigned 53 alcoholics and their spouses to one of three 15-session outpatient behavioural treatments:

(a) Minimal spouse involvement (MSI) in which the spouse simply observed the alcohol abuser's individual therapy

(b) alcohol-focused spouse involvement (AFSI) plus the MSI interventions

(c) alcohol behavioural marital therapy (ABMT) in which all skills taught in the MSI and AFSI conditions were included as well as relationship-focused interventions.

Results during and in the 6 months after treatment indicated that subjects in all three groups had decreased drinking, increased life satisfaction, and increased marital satisfaction, sexual activity, and job stability.

Follow-up data through 18 months from this provided more evidence favouring ABMT.

In a study of methods to maintain change after ABMT, McCrady, Epstein, and Hirsch (1999) randomly assigned 90 male alcoholics and their female partners to fifteen 90-minute weekly sessions of:

(a) ABMT without special maintenance interventions

(b) RP/ABMT which had ABMT plus maintenance interventions based on an RP model and 4 to 8 booster sessions in the 12 months following the main treatment

(c) AA/ABMT which had ABMT plus maintenance interventions based on a 12step AA and Al-Anon model.

In the first 6 months after treatment, patients that completed at least 5 sessions showed increased abstinence, reduced heavy drinking, and overall improvement for all three treatment groups that was similar to other outpatient treatment studies; but there were no group differences.

Longabaugh and colleagues (Longabaugh, Beattie, Noel, Stout, & Malloy, 1993; Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995) conducted a study of patient treatment matching to determine the relative effectiveness of different amounts of BCT for different client characteristics. This study randomly assigned 229 alcoholic patients to one of three 20-session outpatient cognitive behavioural treatments:

(a) Extended cognitive behavioural (ECB) that did not involve significant others

(b) Extended relationship-- enhanced (ERE) that had 8 sessions for the patient with a concerned partner (spouse, relative, or friend) focused on supporting abstinence (using methods closely adapted from McCrady's AFSI procedures) and strengthening the relationship

(c) Brief broad spectrum (BBS) that had 4 sessions of partner involvement with the same goals as the ERE partner sessions

Results showed that ERE was significantly more effective than the other two treatments in increasing abstinence of patients entering treatment with a network unsupportive of abstinence or with a low level of investment in their network, whereas BBS treatment was more effective for patients with either

(a) Both a social network unsupportive of abstinence and a low level of network investment

(b) High investment in a network supportive of abstinence.

BCT with a Relationship Focus and Without a Specific Alcohol-Focused Method

Bowers and Al-Redha (1990) randomly assigned 16 alcoholics and their spouses to standard individual counselling or to a BCT couples group that focused on rehearsal of communication skills and negotiation of desired changes. BCT had significantly lower

alcohol consumption at 6-month follow-up than standard treatment and a trend toward lower consumption at 12-month follow-up.

Monti et al. (1990) randomly assigned 69 male alcoholics in a 28-day inpatient program to: (a) a communication skills training group (CST)
(b) a communication skills training group with participation of a family member most often the spouse (CST-F)
(c) a cognitive behavioural mood management training group (CBMMT).
Patients who received CST or CST-F drank significantly less alcohol per drinking day in the 6 months after treatment than those in CBMMT, but groups did not differ in abstinence rates or time to relapse.

Family Systems Therapy

Family Systems Therapy (FST) has incorporated many core concepts of family systems theory into models of the alcoholic family system (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995; Steinglass, Bennett, Wolin, & Reiss, 1987). Therapy focuses on the interactional rather than the individual level. FST uses a variety of techniques to affect interactions within the family. Greatest emphasis is put on identifying and altering family interaction patterns that are associated with problematic alcohol use. FST can be applied to couples therapy or whole family therapy.

McCrady et al. (1979) evaluated the relative effectiveness of adding joint hospitalization and couples therapy based on a systems perspective to individual treatment for alcohol problems. Married alcoholics were randomly assigned to
(a) Individual involvement in which only the patient attended group therapy
(b) Couples involvement in which the drinker and spouse participated in an outpatient interactional couple's therapy group in addition to concurrent individual treatment groups for each spouse
(c) Joint admission in which both partners were initially hospitalized and then participated in both the couples group therapy and individual therapy groups following discharge.

At 6-month follow-up, findings indicated significant decreases in the quantity of alcohol consumed for both the couples involvement and joint admission treatment groups but not for the individual treatment group.

Orchen (1983) randomly assigned 48 heavy drinkers at an outpatient community mental health centre to:

(a) Brief, strategic family systems therapy

(b) Biofeedback

(c) Relaxation training

Family therapy group improved more than waitlist control and showed a greater reduction in drinking than the other three groups in the 6 weeks from pre- to post-test.

Grigg (1994) randomly assigned 114 male alcoholics and their spouses to 15 sessions of

(a) Experiential systemic couple's therapy

(b) Experiential systemic individual therapy

(c) Individual supportive treatment.

Results showed no significant difference between the groups; and all groups improved from baseline to post treatment and 15-week follow-up on the husbands' alcohol dependence symptoms, couple and family relationships, and symptoms of emotional distress.

Kearney (1984) randomly assigned 10 married alcoholics at an outpatient alcohol treatment program to 10 weeks of twice weekly sessions of either multiple family group therapy or individual conjoint family therapy. Children in the family were included in both treatments. Data collected before and after treatment showed no differences between the treatments on couple or family functioning. Drinking outcomes were not assessed.

Bennun (1988) randomly assigned 12 married alcoholic patients in an outpatient alcohol program to an average of 8 to 9 sessions of family problem solving therapy or family systems therapy. Results showed groups did not differ; and both groups improved from baseline to post treatment and follow up on the alcoholics' alcohol dependence

symptoms, and on husbands' and wives' satisfaction with couple and family relationships, and on children's satisfaction with family relationships.

Zweben, Pearlman and Li (1988) randomly assigned 218 alcohol abusers to either
(a) Eight sessions of conjoint therapy based on a systemic perspective in which alcohol abuse was viewed as having adaptive consequences for the couple
(b) A single session of advice counselling which also involved the spouse.
Results showed that couples in both treatments had significant improvement on all marital adjustment and drinking-related outcome measures; but there were no significant between group differences on any measure.

Other MFT approaches

Corder and Laidlaw (1972) added a 4-day intensive residential couples' group workshop to a standard 4-week inpatient alcohol rehabilitation program. The workshop involved 20 patients and wives in aftercare planning; improving their communication, doing and planning shared recreational activities, AA and Al-Anon meetings, and alcohol education lectures. The control group of 20 patients received equally intensive treatment in the standard individual inpatient rehab program only without spouse involvement. At 6-month follow-up the couples' workshop group had significantly better outcomes of higher sobriety rates, better aftercare participation, more recreational activities together, and less unemployment.

Cadogan (1973) assigned 40 inpatient alcoholics and their spouses to outpatient couples group therapy after the drinkers' hospital discharge or a waiting list control condition. At 6 months after hospital discharge, the 20 alcohol abusers who received the couples' therapy for a 3- to 6-month period had significantly more abstinence and less drinking than the 20 control patients who did not.

Fichter and Frick (1993) studied 100 German alcoholic patients receiving a 6-week inpatient program followed by a recommended 6-week outpatient program. Patients were randomized during the inpatient program to:
(a) A weekly group for relatives plus family sessions on communication

(b) A weekly group to encourage self-help initiatives

Outcome data on whether or not the patient had remained continuously abstinent were collected after treatment and at 6- and 18-month follow-up. Relatives' group had a higher abstinence rate than self-help at discharge from inpatient care but the two groups did not differ at later time periods.

CONCEPTUAL FRAMEWORK

There is a vast body of literature both in India and the West devoted to understanding the marital dynamics involved in alcoholism and ascertaining the deleterious impact that alcoholism could have on the personality and functioning of the spouse. Traits such as neuroticism, higher anxiety levels, depression, low self-esteem and communication apprehension have been reported in wives of alcoholics and attributed to the intense stress and trauma experienced by her in the already stressful domestic environment that she lives in (e.g. Stanley, 2001; Kutty and Sharma, 1988; Rao and Kuruvilla, 1991).

Higher levels of marital conflict and aggression have been found in couples with an alcoholic spouse when compared to marital relationships which were not complicated by alcohol (Stanley, 2006; Stanley & Anitha, 2007). Alcoholism might interrupt normal family tasks, cause conflict and demand adjustive and adaptive responses from family members who do not know how to appropriately respond. Evidently, alcoholism creates a series of escalating crises in family structure and function, which may bring the family to a system crisis.

There is good evidence that approaches directed at improving social and marital relationships, self-control and stress management are effective in the treatment of alcohol problems. Family therapy is effective in motivating alcoholics to enter treatment, marginally more effective than individual alcoholism treatment once the drinker has sought help, and modestly beneficial in supporting aftercare and relapse prevention(Edwards and Steinglass, 1995).

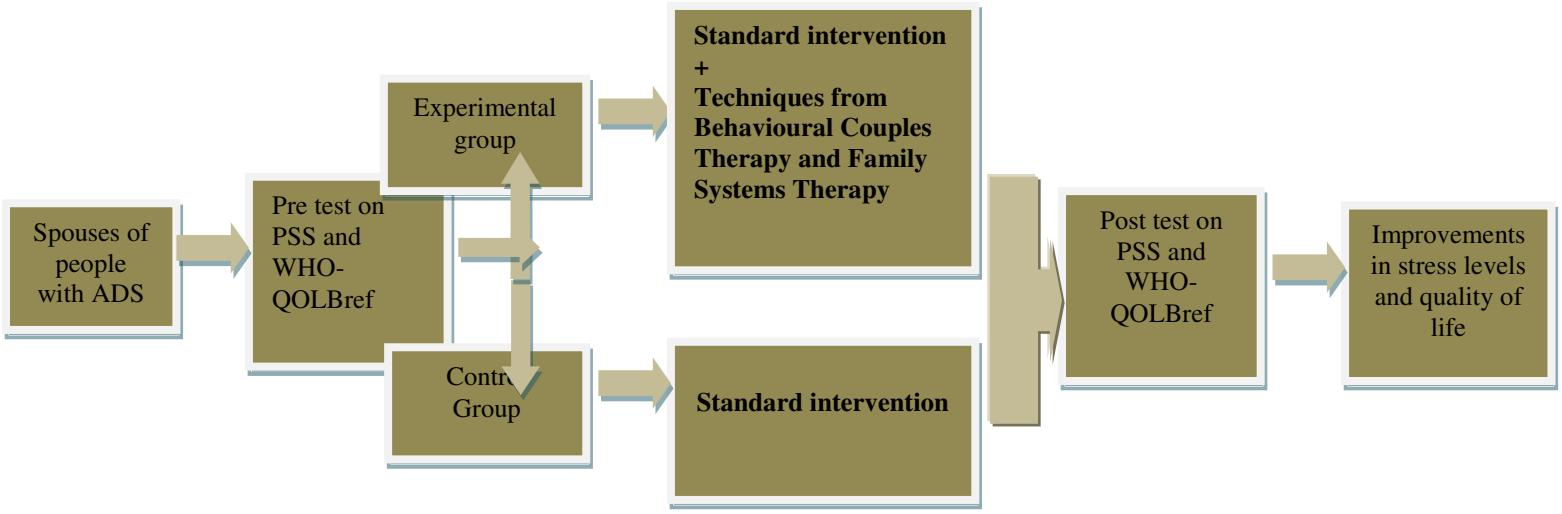
Justification for the study

Despite compelling evidence that families of alcohol and drug abusers are at increased risk of developing lifelong patterns of illness and behavioural problems, access to and adequacy of treatment for these families is limited. Although the substance abuse community recognises that physical and psychological problems are common among families with a substance- abusing member, comprehensive treatment of the families of substance abusers is limited (Lennox, 1998).

Failure to provide treatment for these collateral effects of substance abuse on the family is thought to reduce the efficacy of substance use treatment, increase the risk of relapse and leave untreated pathology among family members. Because substance abuse treatment programmes primarily focus on the abuser, they tend to downplay problems that nonabusing family members experience and can even perpetuate the cycle of abuse by leaving family dysfunction and individual pathology of nonabusing members unchecked (Lennox, 1998). Since Occupational Therapists work closely with family members of people with ADS, a study assessing effect of therapy for spouses was felt.

The investigator has based the current study on the following concepts:

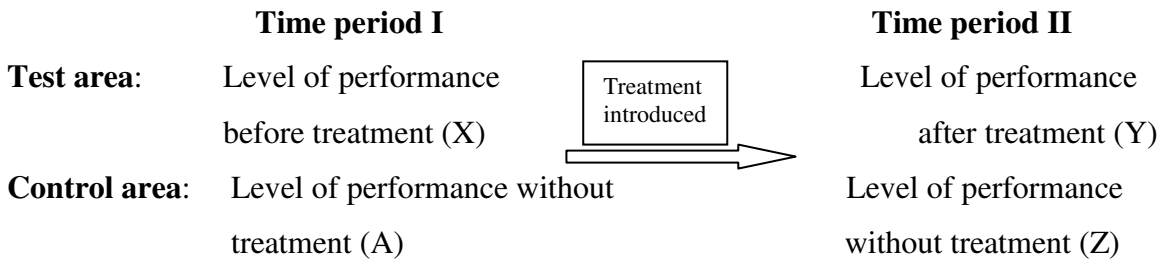
- Alcoholism is an illness which has a detrimental effect on the family as a whole.
- Spouses of people with ADS are affected by their partners' drinking habit and the financial, social and occupational consequences.
- With structured guidance from a professional, spouses will be able to reinforce and support abstinence in their husbands.
- Supportive intervention helps in reducing stress and improving quality of life of spouses of people with ADS.


Spouses of people with ADS
Pre test on PSS and WHO-QOLBref
Experimental group
Contr
Group
Standard intervention + Techniques from Behavioural Couples Therapy and Family Systems Therapy
Standard intervention
Post test on PSS and WHO-QOLBref
Improvements in stress levels and quality of life

METHODOLOGY

RESEARCH DESIGN

A two group pre- test and post- test Quasi -experimental design was used in this study.



Treatment effect =(Y-X) – (Z-A)

VARIABLES

The independent variable in this study was supportive intervention. The dependent variables were the levels of stress and quality of life among spouses of people with Alcohol Dependence Syndrome.

SETTING AND DURATION OF THE STUDY

This study was undertaken in the Occupational therapy Department of Kovai Medical Centre and Hospital, Coimbatore. Duration of the study was one year. Intervention lasted for 2 weeks.

PARTICIPANTS

Twenty four women whose husbands were diagnosed with Alcohol Dependence Syndrome were included in the study. The participants were allotted by purposive sampling into the experimental and control groups.

SELECTION CRITERIA

Inclusion criteria

- Female gender
- Those whose husbands fulfil criteria for ADS
- Those who will be primary caregivers of spouses in future

Exclusion criteria

- Those having history of psychiatric illness/ physical disability and are undergoing treatment for the same

MEASURES

Perceived Stress Scale (PSS-10):

The PSS-10 (Cohen, S., & Williamson, G. 1988) is a 10 item self-report instrument with a five-point scale :(0 = never, 1 = almost never, 2 =sometimes, 3 = fairly often, 4 = very often) measuring stress levels for the previous one month. It is not a diagnostic instrument, but intended to make comparisons of subjects' perceived stress related to current, objective events. PSS-10 scores are obtained by reversing the scores on the four positive items and then summing across all 10 items. Items 4, 5, 7, and 8 are the positively stated items. Scores can range from 0 to 40, with higher scores indicating greater stress. This instrument has been found to have good reliability and validity. The English version of the scale was translated and then back translated to Tamil for use in this study.

WHOQOL-BREF:

The WHOQoL – Bref is a quality of life measure. It is an abbreviated form of the WHOQol – 100. The WHOQoL – Bref consists of 26 items that measure, over the previous four weeks, overall quality of life as well as four specific quality of life domains: Physical, Psychological, Social Relationships & Environment. The 5-point scale ranges from "Not at all" (a score of 1) through to "Completely" (a score of 5). This instrument has been standardised for the Indian population and the Tamil version of the instrument was used for the study.

PROCEDURE AND DATA COLLECTION

The groups were matched on demographic variables and pre-test scores. Subjects in the experimental group received six sessions of supportive intervention lasting two weeks

along with standard intervention. The participants in the control group received standard intervention. All the participants were scored on the PSS-10 and WHOQOL-Bref before and after the time period.

Supportive intervention

The techniques of Behavioural Couples Therapy which were used included alcohol-focused interventions to directly build support for abstinence and relationship-focused interventions to increase positive feelings, shared activities, and constructive communication. The techniques of Family Systems Therapy included identifying and altering family interaction patterns that are associated with problematic alcohol use.

The participants received six sessions of supportive intervention.

- Session I focused on assessment of history of alcohol use, precipitating and maintenance factors of husbands' drinking, the participants' role and attribution of drinking behaviour and problems arising in the relationship due to spouses' drinking behaviour.
- Session II focused on education to the spouse about the course, prognosis and phases of treatment (deaddiction and detoxification).
- Session III focused on education about stress, its causes, effects and effective ways to manage stress in life, especially those arising from spouses' drinking behaviour.
- Session IV focused on the marital relationship where effective communication, planning shared activities as a family, taking equal responsibility for child care and ways of improving overall quality of time spend with family were discussed in a joint session with both spouses.
- Session V focused on relapse prevention strategies where avoiding enabling behaviours, resolving conflicts assertively, managing external cues and monitoring Disulfiram intake were discussed.
- Session VI focused on reviewing previous sessions, discussing warning signs of relapse, encouraging regular follow up and help seeking in case of relapse.

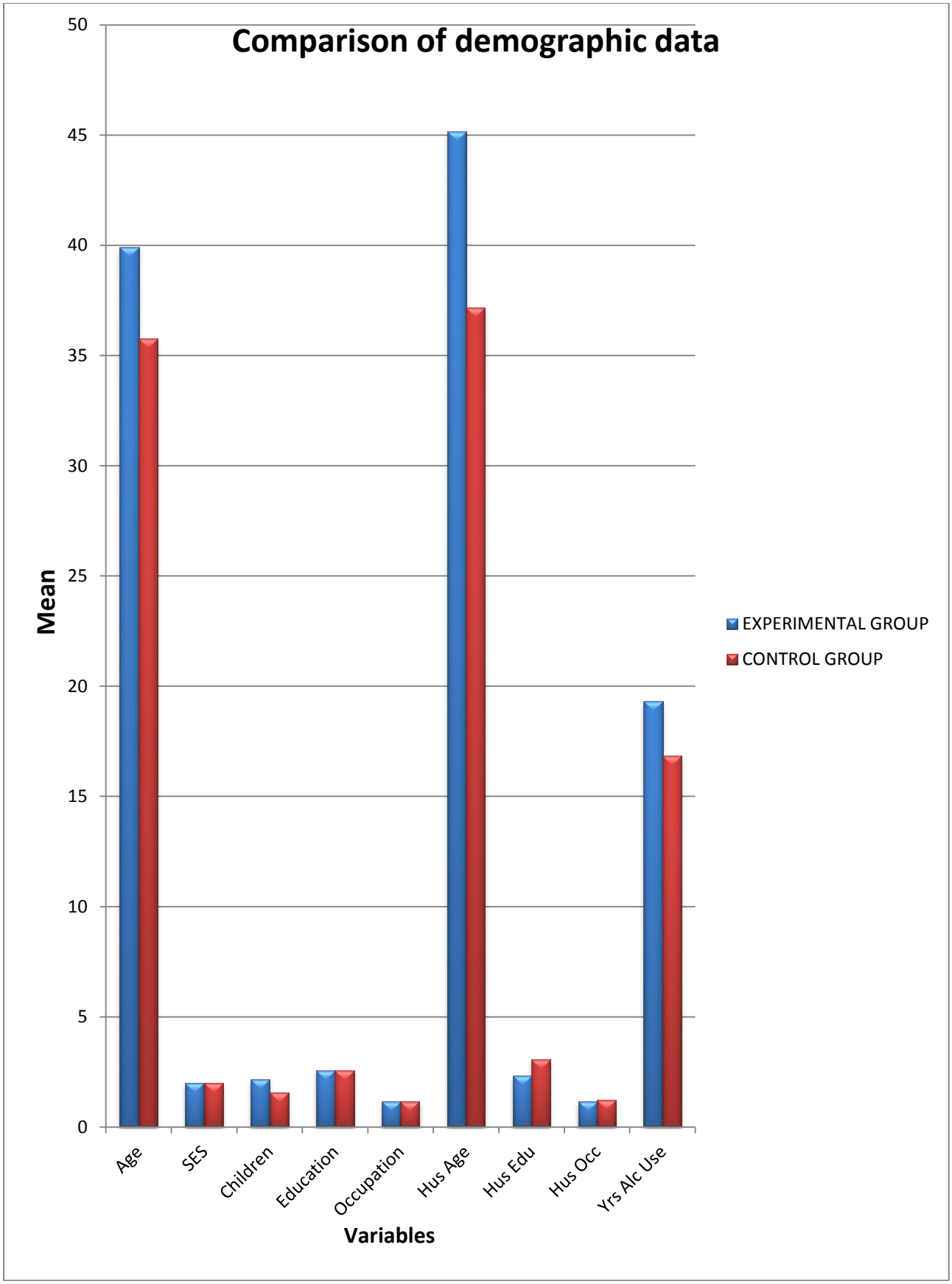
DATA ANALYSIS

Data was analysed using the Statistical Package for Social Science (SPSS) version 16. Analysis was done using t Test to compare the dependent variables between groups. The pre-test, post test and change data was considered for analysis.

TABLE 1 COMPARISON OF DEMOGRAPHIC DETAILS IN EXPERIMENTAL AND CONTROL GROUPS

Variables	Experimental group (N=12)			Control group (N==12)			t	p
	N	Mean	SD	N	Mean	SD		
Age		39.92	8.14		35.75	9.16	1.251	.237
SES	Low=4 Middle= 4 High=4	2.00	.853	Low=1 Middle= 10 High=1	2.00	.426	.000	1.00
No of children		2.17	1.115		1.58	.996	1.629	.131
Educational status	SS=4 HS=2 PUC=2 UG=3 PG=1	2.58	1.443	SS=1 HS=7 UG=4	2.58	1.08	.000	1.00
Occupational status	Homemaker=10 Others= 2	1.17	.389	Homemaker=10 Others= 2	1.17	.389	.000	1.00
Husband's age		45.17	8.211		37.17	9.17	2.270	.044
Husband's Education	SS=4 HS=4 PUC=2 UG=1 PhD=1	2.33	1.497	HS=4 PUC=3 UG=5	3.08	.900	-1.33	.212
Husband's occupation	Business=10 Others=2	1.17	.389	Business=9 Others=3	1.25	.452	-1.00	.339
Years of alcohol use		19.33	7.632		16.83	5.51	.827	.426

The mean age of women who participated in the study was 37 years and most of them were functioning as homemakers. The mean for years of alcohol use for their husbands was 18 years.


Comparison of demographic data
50
45
40
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Mean
Age
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Children
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Hus Age
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Yrs Alc Use
Variables
EXPERIMENTAL GROUP
CONTROL GROUP

TABLE 2 COMPARISON OF BASELINE DATA OF EXPERIMENTAL AND CONTROL GROUPS

Variables		Experimental group		Control group		t	p
		Mean	SD	Mean	SD		
PSS-10		26.0	4.631	26.083	4.737	-.233	.820
WHOQOL Bref	Physical	19.0833	4.925	20.333	6.110	-1.107	.292
	Psychological	15.916	2.7784	18.083	3.579	-2.106	.059
	Environmental	22.92	2.778	26.00	4.632	-1.913	.082
	Social	8.8333	3.8573	10.166	2.1248	-1.140	.279

Table 2 shows that the experimental and control groups are homogenous before intervention, thus allowing further comparison.

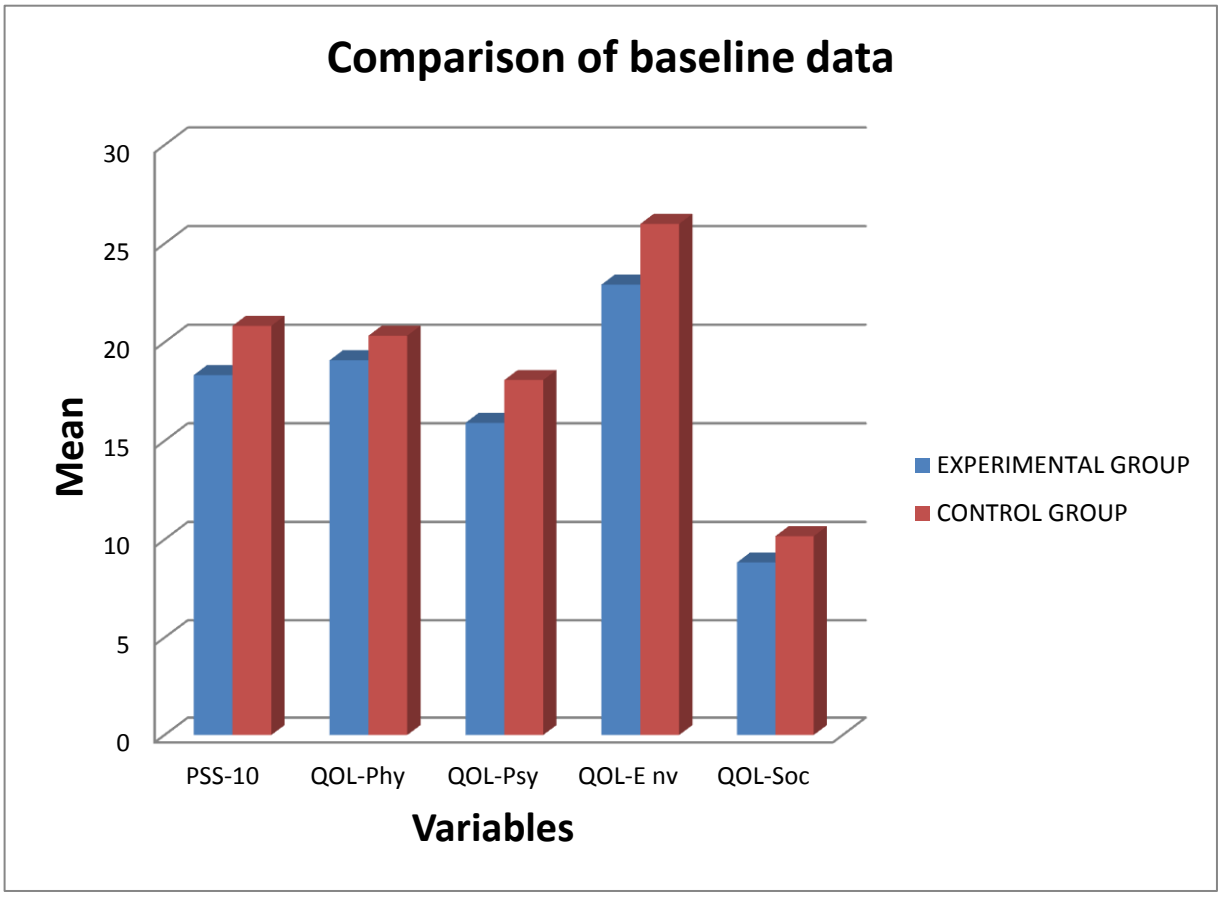


TABLE 3 COMPARISON OF POST TEST DATA OF EXPERIMENTAL & CONTROL GROUPS

Variables		Experimental group		Control group		t	p
		Mean	SD	Mean	SD		
PSS-10		18.3333	4.334	20.833	5.356	-1.397	.190
WHOQOL Bref	Physical	22.0	5.3597	20.250	6.1367	1.297	.221
	Psychological	22.0	3.5929	17.667	3.7739	3.928	.002*
	Environmental	21.50	2.9387	26.083	4.737	-3.421	.006*
	Social	8.0833	3.0289	10.333	2.2696	-3.041	.011*

Table 3 shows significant differences between post test scores of the psychological, environmental and social domains of the WHO QOL-Bref.

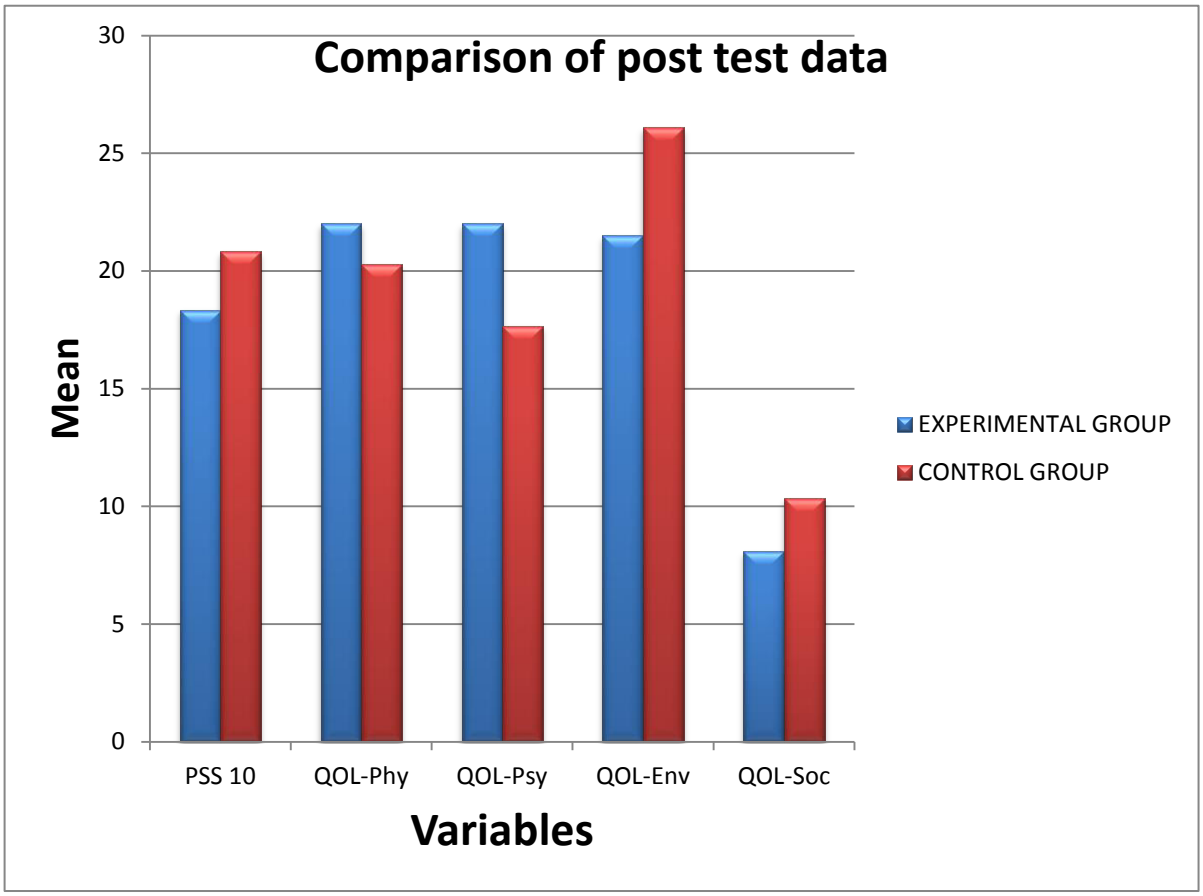


TABLE 4 COMPARISON OF PRE TEST AND POST TEST DATA OF EXPERIMENTAL GROUP

Variables		Pre test		Post test		t	p
		Mean	SD	Mean	SD		
PSS-10		25.58	3.315	18.33	4.334	5.203	.000 *
WHOQOL Bref	Physical	19.08	4.926	22.00	5.360	-5.00	.000 *
	Psychological	15.92	2.778	22.00	3.593	-1.40	.000 *
	Environmental	22.916	2.778	21.50	2.938	1.401	.189
	Social	8.08	3.029	8.83	3.857	-1.915	.082

Table 4 shows significant difference between pre test and post test scores for PSS-10 and the physical and psychological domains of WHOQOL –Bref.

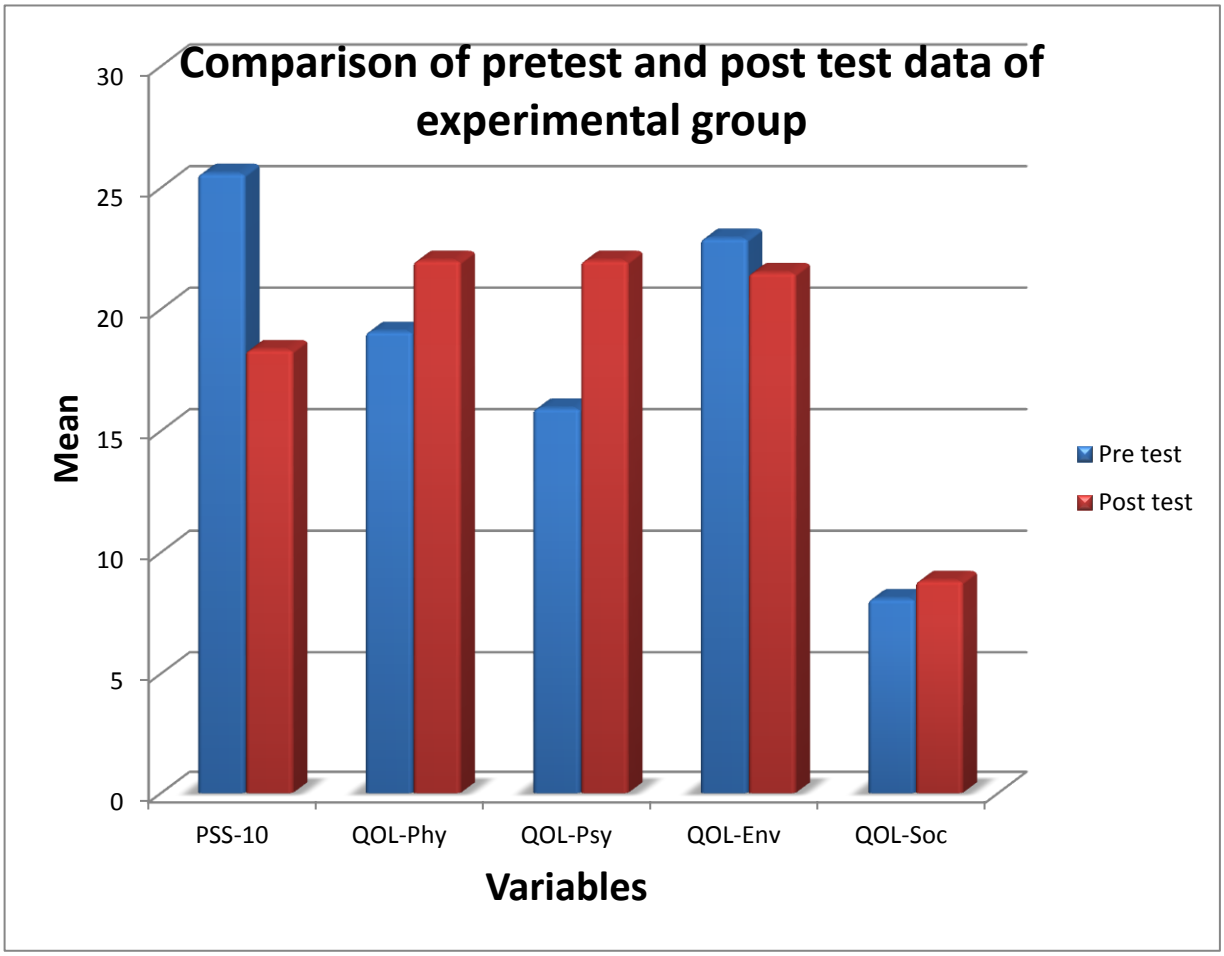


TABLE 5 COMPARISON OF PRE TEST AND POST TEST DATA OF CONTROL GROUP

Variables		Pre test		Post test		t	p
		Mean	SD	Mean	SD		
PSS-10		21.833	5.812	20.833	5.356	2.098	.060
WHOQOL Bref	Physical	20.333	6.110	20.25	6.136	.290	.777
	Psychological	18.0833	3.579	17.666	3.773	.923	.376
	Environmental	26.00	4.631	26.083	4.737	-.233	.820
	Social	10.333	2.269	10.166	2.124	.394	.701

Table 5 shows no significant difference between pre test and post test scores for PSS-10 and WHOQOL –Bref.

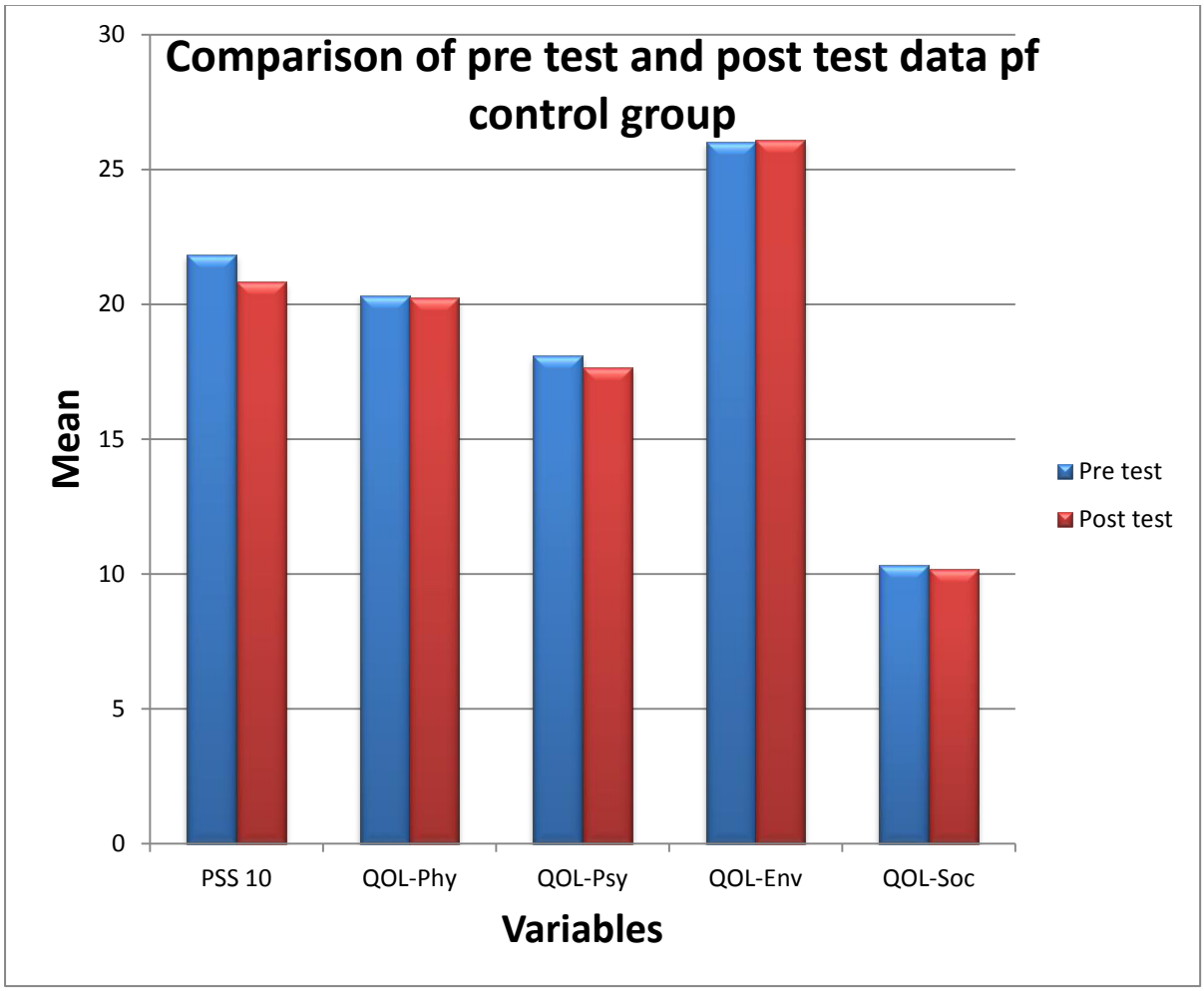
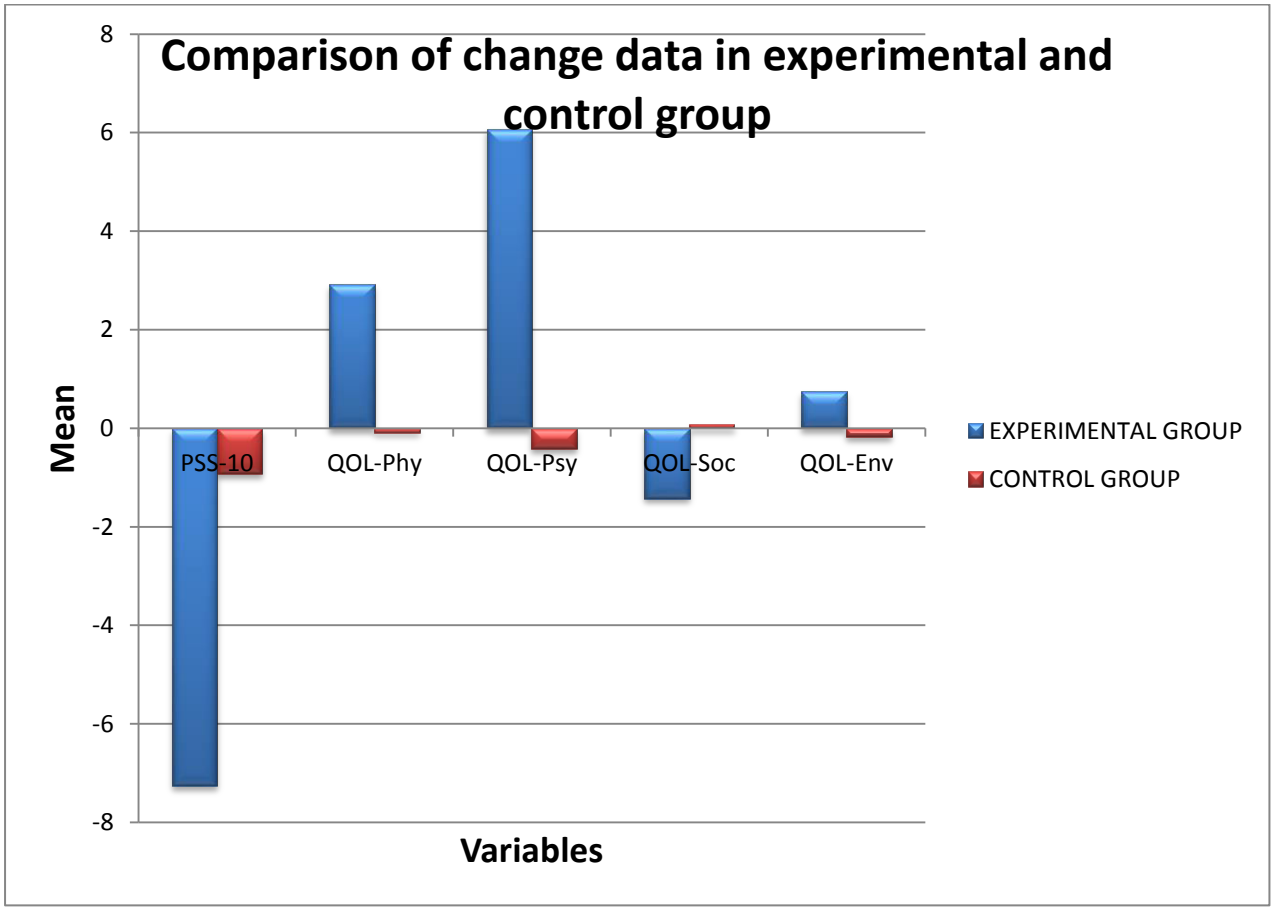


TABLE 6 COMPARISON OF CHANGE DATA OF EXPERIMENTAL AND CONTROL GROUPS

Variables		Experimental group		Control group		t	p
		Mean	SD	Mean	SD		
PSS-10		-7.25	4.827	-.92	1.564	-4.921	.000 *
WHOQOL Bref	Physical	2.92	2.021	-.08	.996	5.911	.000 *
	Psychological	6.08	1.505	-.42	1.564	8.741	.000 *
	Environmental	-1.42	3.502	.08	1.240	-1.310	.217
	Social	.75	1.357	-.17	1.467	1.421	.183

Table 6 shows significant difference in change data for PSS-10 and the physical and psychological domains of WHOQOL –Bref.



DISCUSSION

Evaluating supportive intervention for spouses of people with ADS is important for several reasons. It has already been shown that spouses undergo significant stress due to their partner's alcoholism. This in turn leads to further problems in the already strained family system. It is important to evaluate whether providing education about alcoholism, stress and ways of supporting the spouse in maintaining abstinence helps in reducing stress and improving quality of life of the wives.

The current study was conducted in the Occupational Therapy Department of KMCH, Coimbatore. The study included spouses of people who were diagnosed to have Alcohol Dependence Syndrome. Most of the spouses were home makers in their middle age.

This study evaluated the effectiveness of supportive intervention in decreasing stress levels and improving quality of life among spouses of people with ADS. The overall results support the primary hypothesis.

At the pre-intervention initial assessment the intervention group and control group were matched for age, educational status, SES and occupational status (Table 1). Comparisons of all the baseline variables of both the groups are shown in Table 2 & 3. The groups did not differ in levels of stress or quality of life. The homogeneity of the groups facilitated comparisons between the groups following intervention.

Influence of supportive intervention on stress levels of spouses

There is good evidence that spouses of people with ADS are prone to greater degree of stress and that approaches focusing on stress management are effective in reducing their stress levels(Edwards and Steinglass, 1995; Zetterlind, Hansson, Aberg-Orbeck, and Berglund (1998); (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992; O'Farrell, Cutter, & Floyd, 1985); (O'Farrell, Choquette, Cutter, Brown, & McCourt, 1993; O'Farrell, Choquette, & Cutter, 1998; O'Connor, 1985; McGregor,1990).

The current study supports this premise as there has been shown a significant reduction in stress levels of spouses in the pre test and post test evaluations. There has also been a significant difference in the change data for the experimental and control group,

further supporting this viewpoint. There was a mean decrease of 7.25 in the stress levels of the experimental group as compared to a decrease of .92 in the control group.

Effect of supportive intervention on quality of life of spouses

Teaching the spouse how to reinforce abstinence, decrease behaviours that trigger drinking, decrease behaviours that protect the alcoholic from naturally occurring adverse consequences of drinking, assertively discuss concerns about drinking-related situations, aftercare planning have been found to improve life satisfaction in spouses (Noel and McCrady 1993; (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995; Steinglass, Bennett, Wolin, & Reiss, 1987).

This has held true for the current study as there has been found a significant increase in physical and psychological domains of quality of life of spouses in the pre test and post test evaluations. There has also been a significant difference in the change data for the experimental and control group. There was a mean increase of 2.92 in the physical domain and 6.08 in the psychological domain of the experimental group as compared to a mean decrease of .42 and .08 respectively in the control group.

Emphasis on identifying and altering family interaction patterns that are associated with problematic drinking, joint hospitalization and aftercare planning, , doing and planning shared recreational activities, alcohol education lectures have been found effective in reducing emotional distress in spouses (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995; Steinglass, Bennett, Wolin, & Reiss, 1987; McCrady et al., 1979; Grigg ,1994; Zweben, Pearlman and Li,1988; Corder, Corder, and Laidlaw, 1972; Cadogan, 1973; Fichter and Frick, 1993; Chapman and Huygens, 1988).

This has held true for the current study as there has been found a significant increase in psychological domain of quality of life of spouses in the pre test and post test evaluations. There has also been a significant difference in the change data for the experimental and control group. There was a mean increase of 6.08 in the psychological domain of the experimental group as compared to a mean decrease of .08 in the control group.

This study did not show any significant difference in the social and environmental domains of quality of life either in pre test and post test scores of the experimental group or in the change data for the experimental and control groups. This finding is not surprising as the intervention focused on only the client and his spouse and did not include the children, the extended family or other societal factors.

Insights from the study

Participants were often caught in between their spouses and the extended family. The spouses' family tended to blame the wives for the husbands' alcohol use and failure of treatment.

Often the husbands themselves blamed their drinking behaviour on allegedly unsupportive attitude of their wives.

Few participants were forced to look for employment as unskilled labourers because the financial difficulties brought on by their husbands' drinking made it impossible for them to manage the household expenses.

One participant who wanted to leave her husband was dissuaded from doing so by her own family as they felt it would not be conducive for their social status.

One participant threatened to commit suicide as a last ditch attempt to convince her husband to enter treatment for deaddiction.

LIMITATIONS AND RECOMMENDATIONS

The current study has several limitations. Lack of random sampling and a small sample size potentially limits the generalisability of the results. Also, the tester was the chief investigator, who was not blind to the group assignment. If a systematic bias on the part of the examiner existed, this may have affected the study results.

There are several areas in which future research could benefit this field of study. First, it is not yet clear how the length of the treatment is related to effectiveness. Long term treatment might impart more improvements than found in this investigation. Another question unaddressed by the present study is the duration of improvement. This study did not focus on a follow- up. It is not yet known whether the improvements continue as spouses relapse or maintain their abstinence over a period of time.

This investigation focussed on reduction of stress and improvement in Quality of Life among spouses. Variables like family support, motivation level of husbands, duration of marriage, marital adjustment, and social factors should also be addressed.

CONCLUSION

The results of this study suggest that supportive intervention can reduce stress levels and improve certain domains of quality of life. Both the qualitative and quantitative findings from this study suggest that supporting spouses of people with ADS is an essential part of substance abuse intervention, especially in India. The social structure of our country places greater strain on the wife who often bears the brunt of the unpleasant consequences of the husband's drinking. Ensuring support to the spouse can not only reinforce abstinence, but can also enhance the overall quality of life of the family as a whole. These results should encourage occupational therapists and other professionals to devise treatment techniques to actively involve the spouse in treatment of Alcohol Dependence Syndrome.

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APPENDIX

MASTER CHART

SNO	AGE	HAGE	YOAU	FLY	SES	ES	OS	NOC	H.ES	H.OCC	PSS		QOL1				QOL2			
											PSS1	PSS2	PHY	PSY	SOC	ENV	PHY	PSY	SOC	ENV
1	32	37	10	1	3	4	1	2	3	1	20	**15**	23	18	11	23	**25**	**25**	**13**	**22**
2	38	41	16	1	3	5	2	2	6	2	29	**12**	21	15	9	21	**23**	**21**	**13**	**23**
3	55	65	30	2	3	1	1	2	2	1	25	**14**	19	12	5	28	**23**	**19**	**6**	**20**
4	39	41	20	1	2	4	2	1	3	1	27	**15**	22	17	8	21	**26**	**21**	**9**	**20**
5	31	46	22	1	1	2	1	2	1	1	27	**16**	14	15	5	19	**12**	**19**	**5**	**18**
6	31	33	15	1	1	1	1	2	1	1	19	**17**	23	21	12	24	**27**	**29**	**13**	**23**
7	36	41	19	1	1	3	1	1	1	1	30	**20**	10	14	5	25	**15**	**21**	**5**	**16**
8	36	51	10	1	3	4	1	5	4	2	28	**26**	14	16	6	23	**18**	**20**	**5**	**23**
9	48	51	30	2	2	1	1	1	2	1	26	**23**	18	18	5	25	**22**	**25**	**5**	**25**
10	38	45	20	1	2	3	1	3	2	1	27	**24**	24	14	11	24	**29**	**19**	**12**	**23**
11	42	48	10	1	2	2	1	3	2	1	24	**18**	26	12	13	24	**27**	**18**	**14**	**26**
12	53	43	30	1	1	1	1	2	1	1	25	**20**	15	19	7	18	**17**	**27**	**6**	**19**
13	26	30	15	1	2	4	1	0	4	1	20	**22**	27	17	11	32	**25**	**19**	**10**	**32**
14	38	46	16	1	1	1	2	2	2	2	26	**23**	20	19	10	28	**20**	**17**	**9**	**28**
15	28	34	13	2	2	2	2	1	4	1	18	**19**	28	20	10	26	**29**	**17**	**12**	**26**
16	31	38	12	1	2	4	1	1	4	1	22	**20**	19	17	10	24	**20**	**17**	**10**	**22**
17	38	40	14	1	2	4	1	2	4	1	29	**27**	16	15	12	23	**15**	**16**	**13**	**24**
18	35	40	20	1	3	4	1	2	3	2	10	**8**	26	24	13	31	**26**	**23**	**10**	**32**
19	24	32	15	1	2	2	1	2	2	1	30	**27**	10	12	5	18	**11**	**10**	**5**	**19**
20	56	60	30	2	2	2	1	3	2	2	24	**23**	12	15	8	21	**12**	**16**	**10**	**20**
21	37	32	12	1	2	2	1	2	3	1	23	**23**	24	16	9	21	**25**	**14**	**9**	**21**
22	34	29	15	1	2	2	1	3	2	1	26	**25**	19	20	13	28	**18**	**20**	**13**	**29**
23	33	26	15	2	2	2	1	0	4	1	19	**17**	27	18	11	32	**27**	**19**	**11**	**30**
24	49	39	25	1	2	2	1	1	3	1	15	**16**	16	24	12	28	**15**	**24**	**10**	**30**

WHO QOL - BREF

(FORM - F)

கீழ்கண்டவைகளை படித்தும் உங்கள் உணர்வுகளை ஆராய்ந்தும் கேட்கப்படும் கேள்விகளுக்கு சிறப்பான அல்லது மிகவும் பொருத்தமான பதிலை வட்டமிட்டு காட்டவும்.

		மிகவும் குறைவானது	குறைவானது	குறையுமில்லை நிறையுமில்லை	நன்று	மிகவும் நன்று
1 (G 1)	உங்கள் வாழ்க்கையின் தரத்தை எப்படி கணக்கிடுவீர்கள் ?	1	2	3	4	5

		மிகவும் திருப்தியற்றது	திருப்தியற்றது	திருப்தியாகவுமில்லை அதிருப்தியாகவுமில்லை	திருப்திகரம்	மிகவும் திருப்திகரம்
2(G 4)	உங்கள் உடல் ஆரோக்கியத்தை குறித்து எந்த அளவிற்கு திருப்தியாக இருக்கிறீர்கள் ?	1	2	3	4	5

கீழ்கண்ட கேள்விகள் நீங்கள் கடந்த 2 வாரங்களில் அனுபவித்த ஒரு சில காரியங்களை குறித்து கேட்கப்படுகிறது

		ஒன்றுமே இல்லை	மிக குறைவாக	சுமரான அளவிற்கு	மிக அதிகமான	சொல்லமுடியா அளவிற்கு
3(F1.4)	உங்கள் உடல் வலிகள் நீங்கள் செய்யவேண்டிய வேலைகளை எந்த அளவுக்கு தடுப்பதாக உணர்கிறீர்கள் ?	1	2	3	4	5
4(F11.2)	உங்கள் அன்றாட செயல்பாடுகளுக்கு எந்த அளவிற்கு மருத்துவ சிகிச்சை தேவைப்படுகிறது ?	1	2	3	4	5
5(F4.3)	எந்த அளவிற்கு உங்கள் வாழ்க்கையை அனுபவிக்கிறீர்கள் ?	1	2	3	4	5
6(F24.1)	எந்த அளவிற்கு உங்கள் வாழ்க்கை அர்த்தமுள்ளதாக இருக்கிறது என.உணர்கிறீர்கள் ?	1	2	3	4	5

		ஒன்றுமே இல்லை	மிக குறைவாக	சுமரான அளவிற்கு	மிக அதிகமான	சொல்லமுடியா அளவிற்கு
7(F5.4)	உங்களால் எந்த அளவிற்கு கவனம் செலுத்த முடிகிறது ?	1	2	3	4	5
8(F16.1)	உங்கள் அன்றாட வாழ்வில் நீங்கள் எந்த அளவிற்கு பாதுகாப்பாக இருப்பதாக உணர்கிறீர்கள் ?	1	2	3	4	5
9(F22.1)	உங்கள் சுற்றுசூழல் எந்த அளவிற்கு ஆரோக்கியமாக இருக்கிறது ?	1	2	3	4	5

10(F2.1)	அன்றாட வாழ்விற்கு போதுமான சக்தி உங்களிடம் உள்ளதா ?	1	2	3	4	5
11(F7.1)	உங்கள் உடல் தோற்றத்தை உங்களால் ஏற்றுக்கொள்ள முடிகிறதா ?	1	2	3	4	5
12(F18.1)	உங்கள் தேவைகளை சந்திக்க உங்களிடம் போதுமான பணவசதி உண்டா ?	1	2	3	4	5
13(F20.1)	உங்கள் அன்றாட வாழ்விற்கு தேவையான தகவல்கள் எந்த அளவிற்கு கிடைக்கிறது ?	1	2	3	4	5
14(F21.1)	பொழுதுபோக்கு அம்சங்களுக்கான வாய்ப்புகள் உங்களுக்கு எந்த அளவிற்கு இருக்கிறது ?	1	2	3	4	5

		மிகவும் குறைவானது	குறைவானது	குறையுமில்லை நிறையுமில்லை	நன்று	மிகவும் நன்று
15(F9.1)	எந்த அளவிற்கு மற்ற வரோடு உங்களால் சகஜமாக பழக முடிகிறது?	1	2	3	4	5

கீழ்கண்ட கேள்விகள் அளவிற்கு கடந்த இரண்டு வாரங்களில் நீங்கள் எந்த உங்கள் வாழ்வில் சில அம்சங்களை குறித்து சிறப்பாக அல்லது திருப்தியாக உணர்ந்ததை குறித்து கேட்கப்படுகிறது.

		மிகவும் அதிருப்தி	அதிருப்தி	திருப்தியாகவுமில்லை அதிருப்தியாகவுமில்லை	திருப்தி	மிகவும் திருப்தி
16(F3.3)	உங்கள் தூக்கம் குறித்து எந்த அளவுக்கு திருப்தியாயுள்ளீர்?	1	2	3	4	5
17(F10.3)	அன்றாட வேலையை செய்வதில் உங்களது திறமையை குறித்து எவ்வளவு திருப்தியாக உள்ளீர்கள் ?	1	2	3	4	5
18(F12.4)	உங்கள் வேலை செய்வதற்கான திறனை குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள்?	1	2	3	4	5
19(F6.3)	உங்களை குறித்து எந்த அளவிற்கு நீங்கள் திருப்தியாக இருக்கிறீர்கள்?	1	2	3	4	5
20(F13.3)	உங்கள் தனிப்பட்ட உறவுமுறைகளை பற்றி எந்த அளவிற்கு திருப்தியாக உள்ளீர்கள் ?	1	2	3	4	5
21(F15.3)	உங்களின் தாம்பத்திய உறவை குறித்து எந்த அளவிற்கு திருப்தியாக இருக்கிறீர்கள் ?	1	2	3	4	5
22(F13.3)	உங்கள் நண்பர்களிடம் கிடைக்கும் ஆதரவை குறித்து எந்த அளவிற்கு திருப்தியாக இருக்கின்றது?	1	2	3	4	5
23(F17.3)	நீங்கள் வாழும் இடத்தின் சூழ்நிலைகளை குறித்து எந்த அளவிற்கு திருப்தியாக இருக்கிறீர்கள் ?	1	2	3	4	5
24(F19.3)	நீங்கள் பெறக்கூடிய மருத்துவசேவைகள் குறித்து எந்த் அளவிற்கு திருப்தியாக இருக்கிறீர்கள் ?	1	2	3	4	5
25(F23.3)	உங்கள் போக்குவரத்து வசதிகளைக் குறித்து எந்த அளவிற்கு திருப்தியாக இருக்கிறீர்கள் ?	1	2	3	4	5

கீழ்கண்ட கேள்விகள் கடந்த இரண்டு வாரங்களில் அடிக்கடி நீங்கள் எந்த அளவிற்கு உணர்ந்த அல்லது அனுபவித்த ஒரு சில காரியங்களை குறித்து கேட்கப்படுகிறது.

		ஒரு பொழுதும்	எப்போதாகிலும்	அடிக்கடி	மிகவும் அடிக்கடி	எப்பொழுதும்
26(F8-1)	எப்பொதெல்லாம் எதிர்மறையான உணர்வுகள் உங்களுக்கு ஏற்படுகிறது? (உதாரணம் : நம்பிக்கையின்மை பதற்றம், மனச்சோர்வு போன்றவை)	1	2	3	4	5